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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Education and the Workforce

of the

U.S. House of Representatives

September 11, 2024

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comments on legislation to be considered during the committee's executive session on Sept. 11, 2024. The AHA is providing feedback on the Healthy Competition for Better Care Act (H.R. 3120) and the Transparent Telehealth Bills Act of 2024 (H.R. 9457).

Healthy Competition for Better Care Act (H.R. 3120)

The AHA opposes the Healthy Competition for Better Care Act (H.R. 3120), which would lead to fewer choices for patients and further limit access to care, particularly for patients in urban, rural and other vulnerable communities.

This bill includes harmful contracting provisions that would prevent doctors and hospitals from negotiating reasonable agreements with commercial health insurance plans. These contracting restrictions — known as tiering or steering — would allow insurers to make it more difficult for patients to choose their own doctors and hospitals by steering them to the providers the insurers own or favor. If passed, this bill would limit patient's choice and ability to seek care with their preferred providers and hospitals in their communities.

This bill also would allow large commercial insurers to make financially driven decisions about which hospitals in a network are under contract, enabling them to avoid hospitals serving vulnerable communities or those that serve sicker patients with serious or chronic conditions.

The AHA is concerned that this bill could cause patients in underserved communities, including rural areas with high poverty rates, to lose access to care and health care coverage as insurers could decide the providers in a hospital network to avoid contracting with those in areas the insurer finds less financially desirable. Because providing health care in rural areas is typically more costly than in other areas, an insurer could force rural patients to go elsewhere for services. Forcing patients to travel long distances for care will lead to delays or missed medical attention.

Additionally, this bill may increase rural hospital closures. If insurers are allowed to prevent rural patients from receiving services in their communities, local providers will be unable to cover high fixed operating costs. The resulting financial strain will lead to less access to care and fewer coverage options as insurance plans would not cover the local doctors and hospitals in those rural and high-poverty areas.

Congress should not force providers to agree to unfair tiering and/or steering restrictions, which would allow commercial insurers to further undermine providers' efforts to coordinate high-quality care. Commercial insurers cannot be allowed to profit from contracts premised on the provider's capacity to serve its patients while simultaneously undermining them by encouraging patients to go elsewhere for care. These restrictions are unnecessary because studies show that the vast majority of health insurance marketplaces are highly concentrated. With commercial insurers already having such significant market power, they do not need Congress to grant them additional advantages through these contracting restrictions that will ultimately harm many patients' access to quality care.

Transparent Telehealth Bills Act of 2024 (H.R. 9457)

The AHA opposes the Transparent Telehealth Bills Act of 2024 (H.R. 9457), which would cut hospital reimbursements since payment (including facility fees and any additional services) would be capped for facility-based providers at non-facility rates. Facility fees are for the direct and indirect costs that allow a hospital to continue to provide services to patients and serve the needs of their community. They support the high acuity and 24/7 standby capacity that only hospitals provide and for which payers do not cover the full cost.

The cost of care delivered in hospitals and health systems recognizes the unique benefits they provide to their communities, which are not provided by other sites of care. This includes investments made to maintain standby capacity for natural and man-made disasters, public health emergencies and unexpected traumatic events, and delivering 24/7 emergency care to all who come to the hospital, regardless of ability to pay or

insurance status. In addition, hospital facilities also must comply with a more comprehensive scope of licensing, accreditation and other regulatory requirements compared to other sites of care. These costs can amount to over $200 per patient, resulting in hospitals losing money when providing certain services.

This is especially true for telehealth services. The expansion of telehealth over the past few years has transformed care delivery, improved access for millions of Americans and increased patient convenience. Given the current health care challenges across sites of care, including major clinician shortages, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand. The telehealth value propositions of improving access for geographically dispersed patients and maximizing provider capacity apply equally to facility settings (including hospitals and hospital outpatient departments) and non-facility professional settings. We are deeply concerned that reducing reimbursement for facility-based providers by establishing payment thresholds not to exceed the non-facility rates, will further limit the administration of virtual services for patients and communities.

The originating site facility fee supports reimbursement for staff time (for nurses or other clinical staff to set up the video visit/equipment and proctor the visit), facility space and technology. For example, a patient physically located at a rural health clinic may require a specialty consult from a remote hospital-based provider, in which case the rural health clinic would be able to bill for the originating facility site facility fee to help cover the costs of the technology used in the visit (like secure software), the overhead for facility space (and therefore not available for other in-person appointments) and staff time to support the visit.

Imposing these cuts would endanger the critical roles hospitals and health systems play in their communities, including providing access to care for patients.

Conclusion

Thank you for your consideration of the AHA's comments on these legislative proposals. We look forward to working with you on these important issues.